

THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
ANNUAL
HEALTH BENEFITS PLAN MEMBERS' BILL OF
RIGHTS REPORT

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ANNUAL HEALTH BENEFITS PLAN
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I. EXECUTIVE SUMMARY

The Health Benefit Plan Member's Bill of Rights law passed by the D.C. Council in 1998, as codified at D.C. Official Code § 44-301 *et seq.*, established a procedure for members to appeal adverse decisions by health insurers, which deny, limit, or terminate covered medical services on the grounds of not being medically necessary.

The law requires: 1) health insurers to send written notice of the adverse decisions to the member or the member's representative within five (5) business days of the denial; 2) the written notice to inform the member of internal grievance and external appeal processes; and 3) the member to file an external appeal with the Director of the Department of Health (DOH) or his designee, the Grievance and Appeals Coordinator, within thirty (30) business days after receipt of an adverse decision letter from the insurer.

Furthermore, the law requires: 1) the Department of Health to contract with the Independent Review Organization (IRO) to review appeals and 2) all insurers to report their number of adverse decisions to the DOH.

The law requires that an annual report be compiled that summarizes the data reported to the Department of Health by health insurers.

II. DISTRICT OF COLUMBIA'S GRIEVANCE AND APPEALS LAW

The review of adverse decisions is divided into two parts: a) internal review, which is conducted by the insurer; and b) external review, which is conducted by Department of Health.

A. Internal Review: Insurer's Internal Grievance Process

If an insurer denies services based upon the lack of medical necessity, the insurer must provide its members with a written adverse decision within five (5) business days. The written adverse decision must include the following:

- A clearly stated decision;
- A detailed, comprehensible contractual or medical reason explaining the insurer's decision;
- An explanation of the insurer's internal grievance process;
- Notice that DOH can facilitate an external appeals process if members are dissatisfied with the insurer's grievance decision;
- Notice that members have thirty (30) days from the date of the final adverse decision to file an appeal with the DOH;
- The address, telephone number, and facsimile number of the DOH designee.

1. Requirements of Insurers

D.C. Official Code § 44-301.10 *et seq.* requires insurers to submit an annual report, which chronicles all activity during the preceding year. The report must include the following:

- The name and location of the reporting insurer;
- The reporting period in question;
- The names of the individuals responsible for the operation of the insurer's grievance system;
- The total number of grievances received by the health insurer categorized by cause, insurance status, and disposition;
- The total number of grievances for expedited review categorized by cause, length of time for resolution, and disposition; and
- The total number of appeals for external review categorized by cause, length of time for resolution, and disposition.

B. External Review: Appeals Process of DOH

If members are dissatisfied with the insurer's grievance decision related to the determination of the medical necessity of a claim, members may file an appeal at the following address: ***District of Columbia Department of Health, Office of the General Counsel, Attn: Grievance and Appeals Coordinator, 825 North Capitol Street, N.E., 4th Floor, Washington, D.C., 20002.***

The Grievance and Appeals Coordinator reviews cases to determine whether there should be a referral to an Independent Review Organization (IRO) for medical review. IROs are separate entities under contract with DOH that review appeal cases. They are comprised of certified medical professionals and physicians who specialize in the issue under review. IROs assess appeal cases on the basis of medical records, practice guidelines, and applicable clinical protocols. There is no cost to the members for an independent review. Under normal circumstances, an IRO must render a decision within thirty (30) days after receiving relevant documents. However, IROs must review emergency appeals within seventy-two (72) hours.

1. Additional Appeal Filing Locations

If members have concerns regarding the quality of services rendered by a physician, they may file a complaint at the following address: ***District of Columbia Department of Health, Health Regulatory Administration, 825 North Capitol Street, N. E., 2nd Floor, Washington, D.C., 20002. The telephone number is (202) 442-5888.***

Also, if members have concerns about services covered in their insurer's contract, they may file a complaint at the following address: ***Commissioner of the Department of Insurance and Securities Regulation, 801 First Street, N. E., 7th Floor, Washington, D.C., 20002. The telephone number is (202) 727-8000.***

III. CERTIFICATION OF INDEPENDENT REVIEW ORGANIZATIONS

Upon the certification of an IRO, the Director enforces standards to ensure independent review organizations do the following: (1) review appeals in strict confidentiality; (2) use qualified professionals and medical reviewers; and (3) demonstrate an ability to render decisions in an equitable and timely manner.

An IRO may not be a subsidiary or in any way owned or controlled by a health insurer, or trade association of health care providers. Also, the IRO should not have any material, professional, familial, or financial conflict of interest with the following: (1) insurer; (2) any officer, director, or management employee of the insurer; (3) the physician, physician's medical group, independent practice associates, or the provider proposing the service or treatment; (4) the institution at which the service or treatment should be provided; or (5) the development or manufacture of the principal drug, device, procedure, or other therapy proposed for the member whose treatment is under review.

The Director of DOH has the discretion to deny an appeal assignment to a particular IRO if it yields a conflict or appearance of impropriety. Also, neither the IRO nor an individual working for an external review panel can be held liable for any recommendation presented by the independent review organization, except in cases of gross negligence, recklessness, or intentional misconduct.

IV. STATISTICAL DATA BASED ON APPEALS FILED WITH DOH

During the October 1, 2002 to September 30, 2003 reporting period, DOH's Grievance and Appeals Coordinator received a total of sixty-seven (67) external appeals. The IROs reviewed twenty-three (23) appeals asserting a denial of coverage based upon the lack of medical necessity. One (1) appeal was withdrawn because it was filed before the health insurer had reached its final decision in the internal grievance process. Twenty (20) appeals were rejected because they did not involve medically necessary services. Three (3) appeals were referred to the Department of Insurance and Securities Regulation because they involved coverage or contract interpretation issues. Seventeen (17) appeals were administratively dismissed. Appeals are usually administratively dismissed due to lack of sufficient information, i.e. a letter requesting a member to sign the authorization for the release of medical records or additional information was not responded to within a specified time frame. One (1) appeal was referred to another agency for resolution. Finally, the health insurer reversed two (2) of their adverse decisions due to the receipt of additional information, which the member did not provide the health insurer during the internal grievance process.

V. CONSUMER AWARENESS

The success of the program depends heavily on consumer awareness. In FY 2003, there were approximately fifteen hundred (1,500) requests for assistance from consumers and providers. Requests for assistance were in the form of correspondence, telephone and facsimile inquiries requesting information about the program, assistance with completing necessary forms, and explanations of both the insurer's internal grievance process and DOH's external appeals process.

Despite the explanations, many consumers continuously express confusion and frustration about exhausting the internal grievance and external appeal processes. In fact, such feelings have led several consumers to forgo the processes. Consumers indicate distrust in receiving fair grievance and appeal decisions and cite that their health benefit plan is unresponsive at times.

Research indicates the low volume of appeals DOH received during the October 1, 2002 to September 30, 2003 reporting period is not attributed to the lack of consumer awareness but to their distrust in receiving a fair grievance and appeal decision. It should be noted that the law requires all insurers issuing adverse decision letters to notify the member of the internal and external appeal processes.

Lastly, in an attempt to ensure that members were aware of their appeal rights, DOH utilized various consumer awareness efforts. DOH has done the following: 1) appeared at community meetings, legal seminars, and health programs sponsored by non-profit corporations; 2) developed an informational brochure and distributed it to various health care providers; and 3) created a web site that details information about the Program, including (a) an appeal form and (b) an authorization for the release of medical records form. We have also advertised in local newspapers, and on television and radio.

VI. FINANCING

The health benefit plans fund the operations of the Program. The Mayor is required to assess all health insurers to cover the costs of administering the program. The Department of Insurance and Securities Regulations, via a Memorandum of Agreement with DOH, performs an annual assessment of insurers.

VII. CONCLUSION

Overall, in FY 2003, the Health Benefits Plan Members' Bill of Rights program was successful. The program processed one hundred percent (100%) of the appeals received and provided a

greater degree of assistance to members than in previous years, while ensuring that each member received a full and fair review of their appeal.

Appeals accepted by the DOH in 2003 can be separated into twelve (12) categories: (1) Inpatient Hospital Stays (3 appeals); (2) Emergency Room Services (1 appeal); (3) Mental Health Services (6 appeals); (4) Physician Services (2 appeals); (5) Speech Therapy (1 appeal); (6) Skilled Care Nursing (1 appeal); (7) Durable Medical Equipment (1 appeal); (8) Podiatry services (1 appeal); (9) Dental Services (1 appeal); (10) Chiropractic Services (1 appeal); (11) Home Health Services (1 appeal); and Other (4 appeals).

The range of services determined to be covered by the DOH after being denied by the insurer were:

- Speech Therapy based on medical necessity;
- Durable Medical Equipment based on health insurer's medical policy that Interferential Unit was experimental;
- Room and Board (Acute Care) based on medical necessity;
- Home Services (Jevity/Osmolite infusion) based on medically necessity;
- Other (Botulinum Toxin Treatment) based on health insurer's medical policy that treatment is experimental/investigative for pain;

The health insurers also reported the number of internal grievances, which they overturned (See Tab. B). The combined data shows that in 2003, forty-seven percent (47%) of the internal adverse decisions were upheld, fifty percent (50%) were reversed with four percent (3%) being modified.

Based on the reports submitted, it is clear that the law has had a positive effect on the ability of consumers to obtain medically necessary services. The Health Insurer's Annual Grievance Reports are set forth in the attached Appendix.

VIII. RECOMMENDATIONS

While the program is successful there are measures that should be enacted to ensure that the health consumer's rights are fully protected. Therefore, in accordance with D.C. Official Code Sec. 44-301.10 (d), the following recommendations are made:

- (1) Determinations of the Independent Review Organizations should be binding on both parties or at a minimum the health benefit plan. Under current law the determinations are not binding. Therefore, if the health insurer decides not to abide by the determination of the independent review organization, the member

would then have the expenses and time associated with seeking a remedy through the courts.

- (2) The DOH should have regulatory authority under the law. The DOH should have the authority to levy fines when a health insurer fails to follow the law, regulations or its internal grievance procedures.
- (3) The definition section of the law should be reviewed to ensure that they are consistent with current practice definitions. (Example: “Health Insurer”, use HIPPA’s definition to ensure no impact on self-insured plans under ERISA).

Proposed legislation to implement the above recommendations will be submitted to the District of Columbia Council during the first quarter of 2004.

**SUMMARY OF APPEALS REVIEWED BY INDEPENDENT REVIEW
ORGANIZATIONS
LISTED BY INSURER
OCTOBER 2002 - SEPTEMBER 2003**

Insurer	Total	Insurer Upheld by IRO	Insurer Reversed by IRO	Insurer Modified by IRO
CareFirst	11*	2	8	0
Guardian Life Insurance Co.	2	1	1	0
Kaiser Permanente	2	2	0	0
MAMSI	3*	2	0	0
Mutual of Omaha	1	1	0	0
New York Life	1	1	0	0
People's Benefit Life	1	1	0	0
Unicare	2	1	1	0
TOTAL	23	11	10	0

* 1 pending

**APPEALS BY JURISDICTION
OCTOBER 2002-SEPTEMBER 2003**

DC	MD	VA	OTHER*	TOTAL
19	28	12	8	67

* NY(4), CA(1), FL(1), TX(1), NC(1)

INDEPENDENT REVIEW BY JURISDICTION

DC	MD	VA	OTHER*	TOTAL
6	7	4	4	21

* CA(1), TX(1), NY(2)

**SUMMARY OF APPEALS REJECTED BY DIRECTOR
(BY INSURER)
OCTOBER 2002 – SEPTEMBER 2003**

INSURER	TOTAL
Aetna	2
CareFirst	4
Guardian Life	1
Kaiser Permanente	7
MAMSI	6
TOTAL	20

**SUMMARY OF APPEALS REJECTED/REFERRED BY DIRECTOR
(BY INSURER)
OCTOBER 2002 - SEPTEMBER 2003**

INSURER	TOTAL	REFERRED TO
CareFirst	3	Department of Insurance & Securities Regulation

**TOTAL APPEALS FILED
OCTOBER 2002 - SEPTEMBER 2003**

APPEALS FILED	67*
Referred to Department of Insurance and Securities Regulation	3
Referred to Other	1

DECISIONS	
Insurer Upheld by Independent Review Organization	10
Insurer Reversed by Independent Review Organization	11
Insurer Modified by Independent Organization	0
Insurer Reversed Itself After Appeal Filed	2
Referred back to Member to Exhaust Internal Appeal Process	0
Appeal Withdrawn	1
Appeal Rejected	20
Appeal Administratively Dismissed	17

***2 pending**

**SUMMARY OF APPEALS REFERRED TO
INDEPENDENT REVIEW ORGANIZATIONS
(LISTED BY SERVICE TYPE)
2003**

Type of Service	Total	Insurer Upheld (DOH)	Insurer Reversed (DOH)	Appeal Rejected (DOH)
Inpatient Hospital Services	3	2	1	0
Emergency Room Services	1	0	1	0
Mental Health Services	6*	3	1	0
Physicians' Services	2	2	0	0
Laboratory and Radiology Services	0	0	0	0
Pharmacy Services	0	0	0	0
PT, OT, and ST Services / Inpatient Rehab Services	1	0	1	0
Skilled Nursing Services	1	0	1	0
Durable Medical Equipment Services	1	1	0	0
Podiatry Services	1	0	1	0
Dental Services	1	1	0	0
Optometry Services	0	0	0	0
Chiropractic Services	1	1	0	0
Home Health Services	1	0	1	0
Other	4	1	3	0
Total	23*	11	10	0

* 2 pending

SUMMARY GRIEVANCE DATA SUBMITTED BY INSURER*
(2003)

INSURER'S NAME	GRIEVANCES REPORTED BY INSURER	GRIEVANCE DECISIONS UPHELD	GRIEVANCE DECISIONS REVERSED	GRIEVANCE DECISIONS MODIFIED
Aetna Health Care, Inc.	0	0	0	0
Allianz Life Insurance Co. of North America	1*	0	0	0
AmeriGroup, District of Columbia	2	0	2 (100%)	0
Ameritas Life Insurance Co.	0	0	0	0
Capitol Community Health Plan	0	0	0	0
CareFirst Group Hospital & Medical Services	132	70(53%)	53(40%)	9(7%)
CareFirst BlueChoice	54	20(37%)	32(59%)	2(4%)
CIGNA Healthcare Mid Atlantic Inc.	8	6(75%)	2(25%)	0
Clarendon National Insurance Co.	0	0	0	0
Connecticut General Life Insurance Co.	26	14(54%)	10(38%)	2(8%)
Fortis Benefits Insurance Co.	5	3(60%)	2(40%)	0
Fortis Insurance Co.	19	11(58%)	8(42%)	0
GE Financial Employer Services Group	0	0	0	0
GE Group Life Assurance Co.	0	0	0	0

George Washington Health Plan	0	0	0	0
Golden Rule Insurance Co.	0	0	0	0
Guardian Life Insurance Co. of America	17	6(35%)	11(65%)	0
Health Rite Inc.	0	0	0	0
John Alden Life Insurance Co.	25	20(80%)	5(20%)	
Kaiser Permanente	178	73(41%)	101(57%)	3(2%)
MAMSI Life and Health	96	44(46%)	49(51%)	3 (3%)
MD-Individual Practice Assoc. Inc.	35	14(40%)	20(57%)	1 (3%)
Mutual of Omaha	2	2(100%)	0	0
Optimum Choice	339	150(44%)	181(53%)	8(3%)
Pacific Life & Annuity Co.	0	0	0	0
Principal Financial Grp.	0	0	0	0
Reliance Standard Life Insurance Co.	5	5(100%)	0	0
Trustmark Insurance Co.	0	0	0	0
UniCare	1	1(100%)	0	0
United Health Care Insurance Co.	5	3 (60%)	2 (40%)	0
United Health Care of the Mid-Atlantic Inc.	1	1(100%)	0	0
United Wisconsin Life Insurance Co.	2*	1	0	0
Total	953	444(47%)	478(50%)	28

* Pending